



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MITCHELL D BROOKS MD

Respondent Name

CITY OF FORT WORTH

MFDR Tracking Number

M4-15-1589-01

Carrier's Austin Representative Box

Box Number 04

MFDR Date Received

January 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am in receipt of an EOB denying payment for this bill for a Designated Doctor Exam, which states: "EFFECTIVE 9/1/05, PROVIDERS HAVE 95 DAYS TO SUBMIT BILLS TO THE INSURANCE CARRIER FOR REIMBURSEMENT. YOUR BILL EXCEEDS THIS LIMIT REIMBURSEMENT IS DNIED IN ACCORDANCE WITH SECTION 408.027 OF THE ACT." However, this is incorrect

This bill was submitted to the carrier on November 21, 2014- please see the underlined time-stamp in the top, right hand corner of the CMS-1500. Additionally, the report was faxed to the adjuster on November 20, 2014, to the fax number listed on the DWC-32 (Both of these dates are within 95 days of the date of service, as November 23 would have been 95 days after August 20, 2014."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This will acknowledge receipt of the request for medical fee dispute resolution by CorVel Healthcare Corporation (CorVel), Third Party Administrator for the City of Fort Worth on the above referenced claim.

In review of the dispute packet submitted by the requestor, Mitchell D. Brooks, MD, CorVel maintains that denial was issued in accordance with 28 Texas Administrative Code (TAC) Chapter 133 medical bill processing rules in effect at the time services provided. CorVel respectfully notes a paper medical bill in the form of a CMS-1500 billing form was received on 12/05/14 (107 days) from health care provider."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 20, 2014	CPT Code 99456-W5-NM, 99456-W6-RE and 95851	\$350.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of claims by health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical bill.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 29 – Time limit for filing claim/bill has expired
 - NM – Not at maximum medical improvement
 - RE- Return to work and/or Evaluation of Medical Care
 - W6 – Designated Doctor Examination for Extent
 - 97 – Charge included in another charge of service
 - R38 – Included in another billed procedure
 - W5 – DD exam with IR or MMI

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that “Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.” 28 Texas Administrative Code §102.4(h) states that “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.” Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for the disputed services.”

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

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Signature	Medical Fee Dispute Resolution Officer	4/3/15 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** along with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812

Health care providers may verify workers' compensation insurance coverage and contact information from our website at www.tdi.texas.gov/wc/employer/coverage.html or for additional assistance call the TDI-DWC Insurance Coverage section at **800-372-7713**.